hypertension. He was very cooperative. He filled his prescriptions and complied with all instructions. Whenever his blood pressure rose or a modification in therapy was needed, he changed his medications and management as prescribed. He never complained. He was an ideal patient. This continued for five years. I attended him regularly on a monthly basis. His wife, who usually accompanied him on these visits, was content.

About five years later I was called to see his wife at their home. Glancing about I saw an open closet with shelves filled with prescription bottles. On inspection, I found every medicine I ever prescribed for the five years I treated her husband. Each bottle was filled, just as it had come from the pharmacy. Every prescription I ever prescribed had been filled, but never touched. The patient had had every prescription refilled whenever it was due. He had kept tab whenever a refill was necessary.

When questioned as to this deceit, he stated he wanted to keep me happy.

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Who Was Sir William Osler?

TO THE EDITOR: Professor Geyman's proposal[1] in the June issue to revive the Oslerian tradition depends on knowledge of the tradition, a subject that I began to investigate in 1962 at the University of Rochester by quizzing interns and residents. The study was suspended in 1966 during postgraduate study in London, then resumed in 1967 at Pacific Medical Center in San Francisco, where we see interns and residents from a broad range of US medical schools. Lectureships at other institutions made possible inclusion of some of those house staff. Over 400 have responded.

As a neurologist, my own interests in the Oslerian tradition are both broader and narrower than Geyman's. The survey consisted of three questions:

1. *Who was Sir William Osler?* (A correct answer included knowledge of his famous textbook of medicine, or of his role in the founding of the medical school at Johns Hopkins, or of his later career at Oxford. Any knowledge in just one of these areas was considered a passing answer.)

2. *Who was Harvey Cushing?* (A passing answer included knowledge that Cushing was a pioneer in American neurosurgery, or some knowledge of his contributions in hypothalamic-pituitary disorders, or merely knowledge of his prize-winning biography of Osler.[2] Answers such as "He was a famous endocrinologist" were not acceptable.)

3. *Who was John Fulton?* (Correct answers included knowledge of Fulton's editions of Howell's *Textbook of Physiology,* or any knowledge of Fulton's contributions to neurophysiology, or merely knowledge of Fulton's prizewinning biography of Cushing.[3])

In this study, largely of United States citizens and graduates of many of our leading medical schools and universities, only three participants were able to meet the criteria for identification of Osler; two of these and only one other were able to identify Cushing; none of the participants identified Fulton. Faculty were not invited to participate, but I would be interested in Professor Geyman's score, since his bibliography[1] does not include the Cushing biography of Osler.

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Comment on Ethical Crises and Cultural Differences

TO THE EDITOR: The article "Ethical Crises and Cultural Differences"[1] is made especially interesting by the authors' conclusions concerning the hazards of stereotyping and generalizations. Some points, however, merit more consideration in view of the purpose of the article.

The case study, for instance, seems more Egyptian than Arab; the assumption of homogeneity among Arabs, and the emphasis on the "core of Arabism," can lead to some misunderstandings. Also, Drs Meleis and Jonsen projected a subjective "reading" of a case amenable to several interpretations. The authors point out that probing medical questions are often viewed by Arab-American patients as unnecessary and intrusive, and hence undermine the patient-doctor trust. To an Arab patient, though, fewer questions are not an indication of either better care or a more competent physician. My experience with Egyptian, Kuwaiti, Saudi, Palestinian, Syrian and Sudanese patients indicates that questions tend to put patients at ease and are a direct correlate of a physician's concern.

Indeed, Arab patients take issue neither with excessive questioning in itself nor with its subject-matter; the problem usually resides in the phrasing of the questions, which can make clinically pertinent inquiries seem irrelevant and insulting. A case in point is asking the pious Mr Ahmed about his liquor consumption, or questioning a single girl as to her use of contraceptives, or inquiring whether a male patient is homosexual. If any of these questions are too blatantly put, they are unacceptable to an Arab patient and will undercut his or her respect for the physician. The necessary inquiries can be tactfully and privately posed, so as not to insult the patient.

After tactful inquiry and providing the necessary information to the patient, there is still the issue of consent. The article stresses patient consent as a pillar of Western values applied to medicine—patient autonomy, individual freedom and the like. The stress on patient consent, though, cannot claim such noble origins. Rather, it has proliferated with the malpractice suit and reflects definite shortcomings in confidence, trust and integrity in the doctor-patient relationship.

The shortcomings are much more a Western than a European phenomenon, and it is for this reason that a request for consent would sound irrelevant to Mr Ahmed and a sign that his doctor neither trusts him nor is worthy of his trust. Had Mr Ahmed been approached from the view that consent is "routine" for the protection of doctor, patient and hospital, he probably would have signed gracefully. In my judgment, this applies to all patients from countries where legal prophylaxis does not accompany medical practice. In the Arab countries, patients do not sue their doctors because they trust their sincerity and view them only as tools of God. Only with the most flagrant negligence can this trust be undermined.

Subjectivity, then, when taken to extremes can become bias, as is evident in the authors' assessment of the options available to patients in the United States versus elsewhere. As long as the science of medicine is reasonably uniform, no gulf of options exists between here and the Gulf.

Similar biases, which undermine the article's quest for enhanced understanding, involve a cultural differentiation of the view of deceit—that it is reprehensible here but not so elsewhere. The deceit discussed is in relation to provision of information to the patient. Here, though, honesty is confused with bluntness. The difference between American and Arab patients and physicians is not in the amount of information provided or withheld but in the methodology of communication.

As physicians, we should admit to ourselves that we deal in probability rather than absolute truths; if this fact alone is remembered, it changes the tone of communication between patients and doctors, be they Arabs or Anglo-Saxons. When, for instance, we are informing a patient of a fatal disease, we should recall the spontaneously cured cases of hypernephromas in the literature (three in 1978), and the rare cases of lung cancer that improve, or the patients whom we have followed up for four to six years after they have been given four to six months on probabilistic terms. It is these considerations—a refusal to shut hope's door—that most differentiates the manner of an Arab from an American physician, rather than the former's alacrity to deceit.

Another point of contention with the authors relates to their assessment of the role of the patient's family. Certainly, an Arab family may seem more attached to the patient and more emotional about the medical goings on. This does not, though, indicate an inability to prepare for death on their part. In my experience, once word is passed that a case is critical, the family goes behind closed doors to make their preparations, incorporating the full spectrum of details from funeral arrangements to outstanding debts.

The issue of death, it must be pointed out, is cast differently between Egyptians and non-Egyptian Arabs. The latter tend to accept death matter-of-factly. Egyptians, however, have behind them a 7,000-year culture built on attempts to defy death and achieve immortality; hence their acceptance of death is more limited, and the grief more open.

In general, death in the Middle East is viewed more fatalistically than in the West—as the will of God. This naturally tends to make Arabs more reticent about death; this silence is an expression of long-held beliefs about life and death, common to all Moslems as expressed by the saying related to the Prophet: "Work in the present as if you will live forever, and work for the hereafter as if you will die tomorrow."

Finally, a last comment about bringing a "Moslem Sheikh" to the bedside of the sick patient was most unfortunate. It expressed bringing a layman to a professional technological situation and is a declaration of bankruptcy of the medical institution; most of these people believe in healing through medicine (teachings of the Prophet to seek medicine and medical advice for any sickness) not through the influence of prayer.

In Islam there is no clergy, so even from the religious point of view his presence looks both irrelevant and ominous. In my judgment it would have been more productive in this case to find an Egyptian physician who belonged to the same religion and spoke the same language to help bridge the gap that I think was easily bridgeable.

This valuable article, meant to bring people closer together and to create a common understanding, might unwittingly be counterproductive if we don't emphasize that kindness, sympathy and love are elements of a universal language, and these elements will work only if they are felt and made real. Human beings at a time of suffering and need will feel and appreciate the sincerity of those who care for them.

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1. Meleis AI, Jonsen AF: Ethical crises and cultural differences (Medicine in Perspective). West J Med 1983 Jun; 889-893

Correction: Arsenic Poisoning

AN ERROR OCCURRED in the case report by Selzer and Ancel on chronic arsenic poisoning in the August issue (Selzer PM, Ancel MA: Chronic arsenic poisoning masquerading as pernicious anemia. West J Med 1983 Aug; 139:219-220). In the Discussion section on page 220, the third sentence should read as follows: "In *arsenic poisoning,* the erythrocytes are primarily normocytic and normochromic, and basophilic stippling is common; hypersegmented neutrophils are absent or rare, and relative eosinophilia may be seen." —THE EDITORS